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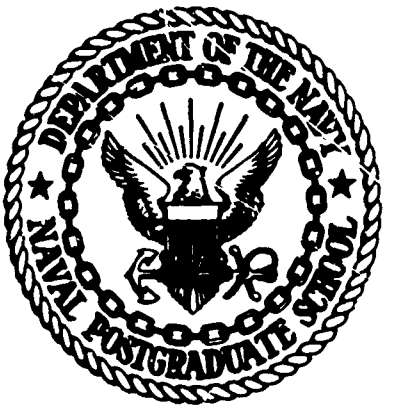

A HISTORY OF MILITARY DEPENDENT

MEDICAL CARE PROGRAMS

by

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August 1975

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As part of a larger research project into the CHAMPUS (Civilian Health and Medical Program for the Uniformed Services, the legislative history of military dependent medical care programs was traced to illustrate the Congressional intent behind the CHAMPUS program. This history is used to derive normative implications for the form of future program structure changes.

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INTRODUCTION

This report traces the legislative history of the development of the presently configured program of providing dependent health care. This consists of the military facilities utilized by the dependents of active duty retired military personnel, and their dependents, as well as the Civilian Health and Medical Program for the Uniformed Services (CHAMPUS) which assists the same groups to receive care in the private health care sector.

Due jointly to the loss of the physician draft and the ever increasing impact of the rising private sector health costs on the resources necessary to operate the military health care delivery system, there have been suggestions from many quarters that the traditional magnitude and mode of providing dependent health be altered. The authors undertook an extensive look at the CHAMPUS portion of this program and believe that the present report may help to provide some perspective to the current debate.

Other reports will deal with the CHAMPUS organizational structure and operation, as well as the description and analysis of the CHAMPUS Programming and Budgeting Process as it has evolved.

THE LEGISLATIVE PROCESS IN PERSPECTIVE

1. Pre-Dependent Medical Care

In 1799 the "officers, seamen, and marines of the Navy of the United States" began contributing twenty cents per month to a fund to provide for their care when they became sick or disabled [Ref. 1]. A few years later, in 1811, another law as passed that transferred the above contributions to a special "fund for Navy hospitals." Provisions of this "Act to establish Naval Hospitals" stipulated that officers, seamen, and marines on active duty or entitled to a pension would be admitted to the Navy Hospitals thus established [Ref. 2]. Since the law stipulated only active duty persons could be admitted to these newly established naval hospitals, it must be assumed that their dependents would have to obtain medical care from civilian sources. It must also be assumed that the dependent would have to pay all costs for such care.

In the Appropriations Act for the Army in 1884, the United States Congress first recognized the need for medical care for military dependents with the following proviso:

> Be it enacted by the Senate and House of Representatives of the United States of America in Congress Assembled: That the following sums be, and the same are hereby, appropriated, out of any money in the Treasure not otherwise appropriated, for the support of the Army for the year ending June thirtieth, eighteen hundred and eighty-five, as follows: ... For purchase of medical and hospital supplies, expenses of purveying depots, pay of employees, medical care and treatment of officers and enlisted men of the Army on

> duty at posts and stations for which no other provision is made, advertising, and other miscellaneous expenses of the Medical Department ... Provided, That the medical officers of the Army and contract surgeons shall whenever practicable attend the families of the officers and soldiers free of charge, and ... [Ref. 3]

But note the condition implied in the law, "at posts and stations for which no other provision is made." It is difficult to discover what is meant by this phrase but one might read a meaning into it by recalling the times during which it was written. In 1884, the Wild West was still being settled. Several Indian uprisings were recorded during that era. It would seem, then, that the proviso was aimed at caring for the dependents of Army personnel stationed at the scattered forts located in the West. Certainly one could assume from historical data that there was a scarcity of surgeons and physicians in the West during this period. There is nothing in this law pertaining to Navy or Marine Corps dependents. One must assume that since these persons normally lived in coastal towns and cities they would be expected to continue to purchase their needed medical care from civilian sources.

Fifteen years later, in a law titled "An Act to reorganize and increase the efficiency of the personnel of the Navy and Marine Corps of the United States," Congress stated, in Section 13 of that law, that, "... commissioned officers of the line of the Navy and of the Medical and Pay Corps shall receive the same pay and allowances, except for forage,

as are or may be provided by or in pursuance of law for officers of corresponding rank in the Army ..." [Ref. 4] The Navy interpreted this law to mean that medical personnel in the Navy's Medical Department could treat dependents of Navy and Marine Corps personnel in Navy medical facilities. Since this Navy Department policy was geared to the Army Appropriation Act of 1884, it must be assumed that Navy and Marine Corps dependents could receive care only at those commands that had naval medical facilities. The phrase "shall whenever practicable" seems to be the guiding factor in determining when such care would be provided. It would also seem that such care may have been provided to only the dependents of officers since enlisted men were not addressed in the Navy Personnel Act of 1899.

In 1943 Congress took action to lay out the first really specific rules pertaining to dependent medical care. In Public Law 51, an act to expand Navy medical facilities, Congress spelled out that dependent medical care in Navy facilities would be provided "only if adequate care was not available in an appropriate non-Federal hospital." Care to be provided under those circumstances was "only for acute medical and surgical conditions, exclusive of nervous, mental, or contagious diseases or those requiring domiciliary care" [Ref. 5]. This act also defined, for the first time, the word "dependent." A dependent was to include a lawful wife, an unmarried dependent child under 21 years of age, and a mother

or father of the member if they were in fact dependent on the serviceman. Widows of deceased naval and Marine Corps personnel were entitled to the same care as were dependents. The act further stated that outside the limits of the United States, government employees and contractors and their dependents would be eligible for emergency medical care provided there were no adequate non-federal hospital facilities available nearby.

The act further specified that when naval facilities are utilized by dependents, they would be required to pay a per diem rate prescribed by the President. There is nothing in this Act that includes, or excludes, members of the Army and their dependents. The Act does state, however, that dependents of Coast Guard personnel, when that unit was operating as a part of the Navy, were included among those persons considered eligible to use Navy medical facilities. Thus, prior to the end of World War II military dependents had received the enfranchisement for medical care in military facilities, albeit for limited purposes of emergency treatment for acute conditions. It should be noted that this law permitted dependents to receive inpatient care in military facilities only if it were not available in the civilian community. One must then assume that dependents were required to purchase most of their medical care from civilian providers.

2. Dependent Medical Care - WWII to 1956

The Second World War saw the rapid expansion of the Armed Forces and tremendous leaps forward in technology. The field of medicine also benefitted as physicians learned new techniques, the "wonder drugs" of the sulfa and penicillin families came into use, and, in general, medical services provided to the sick advanced.

But, the military dependent could receive hospital care in military medical facilities only for "acute medical and surgical conditions." It was not until 1949 that the Congress again addressed itself to the problem of dependent medical care. In that year, Congressman Olin Teague of Texas authored a bill which provided that unmarried widows and children of deceased members would be authorized to receive their medical care in medical facilities of the Uniformed Services. This bill, and three others similar in nature, did not get beyond committee status. In 1952, a bill authored by Senator Herbert H. Lehman, was introduced to the Congress. This bill would have permitted the wives and children of enlisted personnel to receive maternity and child care benefits [Ref. 6].

The Defense Department advocated extending the bill to include dependents of officers up to the O-3 pay grade. Opposition to this bill was led by the American Hospital Association who felt that in the near future the majority of the nation's population would be servicemen, veterans, or their dependents. They voiced the fear that "we shall have

socialized medicine without necessity of specific legislation for it" [Ref. 7]. The American Medical Association strongly opposed the bill also. They objected to it "on the grounds no emergency exists and communities can take care of these families" [Ref. 6].

This bill was strongly supported by the American Legion, the American Red Cross, and the Defense Department. The American Legion testified that military installations could provide maternity care for less than one-third of the expected births in 1952. Defense officials testified that military families would have 200,000 births in 1952 and that maternity care could be provided for only 75,000 of them. The American Red Cross indicated that it would be able to furnish financial assistance to only 10,000 military families for maternity care. The remaining families, it was implied, would have to depend on charitable institutions, or worse, either accept less-than-adequate care or no care at all.

In spite of the favorable testimony, the A.M.A. and the A.H.A. views prevailed and the bill was not acted upon prior to the end of the legislative year. In early 1953, the Citizens Advisory Commission on Medical Care for Dependents of Military Personnel referred to as the Moulton Commission made its report to the Secretary of Defense. In it the Commission expressed concern over inequalities of medical care for dependents and recommended civilian doctors and hospitals be used to supplement family medical care given at military

medical facilities [Ref. 8]. The Department of Defense prepared legislation based on these recommendations and sent it to Congress where it was sponsored by Senator Leverett Saltonstall.

Major provisions of this bill required dependents to pay the first $20 plus not more than 10 percent of the total costs of care received at civilian facilities. Maternity care, however, would be entirely paid for by the government. Another section of the bill defined the term "members" of the Armed Forces. There was to be three categories of members of the Armed Forces. The first category included active duty members of the Army, the Navy, the Air Force, the Marine Corps, and the Coast Guard when it was serving as a part of the Navy. Members of reserve components on active duty in excess of 30 days made up the second category and members in a retired or retainer pay status comprised the third category.

The bill also contained the provision that the Secretary of Defense could contract with private insurance companies for dependent care if it could be shown that such plans would be more economical [Ref. 9].

In laying the groundwork for the introduction of this bill, John A. Hannah, Assistant Defense Secretary, had previously testified before Congress that "it has been established plainly that worry about the health of dependents and the availability of adequate care for them in times of sickness or accident has an adverse effect upon morale, particularly

that of men separated from families while on duty overseas" [Ref. 10]. Hearings on this bill were delayed because the Defense Department had not submitted a cost estimate. No further action was completed in that legislative year.

In January 1955, Congressman Carl Vincent introduced a bill in the Committee on Armed Services that was essentially the same as the Saltonstall bill. The bill was designed, according to Defense Department officials, to equalize medical care provided to dependents of Armed Forces personnel [Ref. 11].

As a counter-force to this bill, the Hoover Commission of 1955 advocated the elimination of free hospital medical care for dependents of all servicemen in the United States and suggested a plan for a contributory health insurance system for service families. The suggestion did state, however, that the government would defray part of the cost. This purely voluntary program had a slight catch to it. Those persons who did not take out commercial health insurance would not be eligible for care in civilian facilities. In addition, they would be barred from inpatient care at military medical facilities. The Commission's rationale was that the serviceman had the right and privilege to accept or decline participation in the insurance program it had suggested [Ref. 12].

Opposition by the American Medical Association and the effect of the publicity surrounding the issuance of the Hoover Commission Report forced a revision in the Vincent bill. This revision resulted in an entirely new bill being

introduced into Congress. The new bill allowed dependents medical care in military facilities as long as there was space and staff personnel available. The medical care that they could receive would be limited, as before, to treatment of acute medical and surgical conditions. If space or staff were not available, the dependent had to get a certificate stating that fact and that care in civilian facilities was authorized. The dependent would then have to share in the costs of civilian care by paying the first $10 plus 10 percent of the total cost for each illness [Ref. 13].

In August 1955, the Defense Department's dependent medical care bill was reintroduced into Congress. This year's bill had essentially the same provisions as its predecessors except it called for an insurance program in which the military families contributed up to 30 percent of the monthly premium. A family would not, however, contribute more than the maximum of $3.00 per month. Another new option provided that if no military medical facilities were available and the member declined the insurance program, his dependents could get civilian medical care. The serviceman would be required to pay 30 percent of the first $100 of hospital care and 15 percent of the remaining costs. Outpatient care would cost the member 30 percent of all costs incurred by his dependents [Ref. 14]. A dramatic change in the wording of this bill was the exclusion of widows and children of deceased military personnel as eligible beneficiaries.

In early 1956 still another revised bill for dependent medical care was introduced into Congress by Congressman Vincent. This bill dropped the option that authorized care in civilian hospitals on a payment plan partially subsidized by the government. The bill would allow medical care for dependents at existing medical facilities and provided the opportunity for all military personnel to participate in a basic health insurance plan for wives and children. Additional optional insurance policies would become available for coverage of dependent parents and parents-in-law and for coverage of long-term care diseases such as polio or tuberculosis [Ref. 15]. The basic insurance plan was to cost the serviceman about $3.00 per month. The cost of the entire premium of the optional policies, if purchased, would be borne by the serviceman.

At hearings on this bill Defense officials stressed the need for dependent medical care as an important morale factor. At the same time these officials insisted that the Armed Forces still wanted to give medical care to dependents at military medical facilities, both as a historic responsibility and as a necessity to the professional efficiency of their physicians [Ref. 16].

By mid-February 1956, the House Armed Services Subcommittee had finished its public hearings and went into closed session to write a finished version of the bill. The final version of the bill, when compared to the previous bills, was

considered as a very liberal bill. The bill, as reported by the Kilday Subcommittee, contained the following important provisions:

a. Dependents would be classed as one of two categories, active duty or retired, without regard to the branch of service of the military man.

b. The government must pay for group insurance for a specific list of services for dependents of servicemen who could not get such care in Defense Department or Public Health Service medical facilities.

c. The government was to work out insurance coverage for dependent parents and the dependents of retired and deceased persons.

d. The dependents would have to pay the first $25 of civilian inpatient hospital costs for each illness.

e. All government medical facilities would charge a uniform per diem subsistence rate to dependents who received inpatient care.

f. Government medical facilities would be open to all dependents regardless of the service affiliation of their sponsor.

g. Coast Guard dependents could utilize Defense Department medical facilities and vice versa.

h. Government medical facilities could make a modest charge to dependents for outpatient care to discourage abuse of the privilege.

i. Retired personnel may receive medical and dental care at government medical facilities subject to the availability of space and staff.

The minimum care to be contracted from insurance plans would be restricted to inpatient care and would include:

a. Hospitalization in semi-private accommodations for not more than 365 days,

b. All necessary services and supplies,

c. Medical and surgical care incident to the hospitalization,

d. Complete maternity care,

e. The required services of a physician or surgeon before and after hospitalization for bodily injury or an operation.

f. Diagnostic tests incident to hospitalization [Ref. 17].

This bill was rapidly approved by the House Armed Services Committee and had passed the House of Representatives by late February 1956 [Ref. 18]. The Senate, however, had different ideas. Their version of the dependents' medical care bill eliminated eligibility for all dependents other than the wives and children. It added Title III Reservists, who had retired with less than eights years of active duty, to the list of persons eligible for care in Defense Department medical facilities. The Senate version further set as the maximum limits of allowable care those limits which the House

had said should be the minimum. A final feature changed the payment plan for civilian inpatient care to $1.75 per day or $25.00, whichever was the greater amount [Ref. 19]. A major factor that was considered, the Senate Armed Services Committee reported, was the liberal medical care privileges private industry was extending in its insurance plans and the large increase in the number of dependents needing care which had resulted in the overloading of some military medical facilities [Ref. 20].

In early May 1956, the Senate had approved their version of the bill and, by the end of the month, a Congressional Conference Committee compromise bill had been approved by both houses of Congress [Refs. 21, 22]. Presidential approval was received in June. Public Law 84-569, the Dependents' Medical Care Act, repealed the proviso in the Army Appropriations Act of 1884 and portions of the Act of 10 May 1943 which pertained to naval personnel. The Navy had stopped deducting money from the pay of Navy and Marine Corps personnel in 1944 in order to simplify accounting procedures although the Acts of 1799 and 1811 had not formally been repealed.

By October 1956, the Defense Department had readied its regulations to implement Public Law 569. Under these regulations, dependents would be provided "Dependents Authorization for Medical Care" cards naming the eligible wife and children [Ref. 23]. Everyone was certain that this law " . . . assures hospital care at all times to the wives

of active duty personnel. It removes one of the greatest sources of worry to our servicemen and servicewomen around the world" [Ref. 24]. Outpatient care was not, however, addressed in this law. Such care, it must be assumed, had to be obtained from civilian providers with the dependent paying the full cost.

3. Dependent Medical Care - 1956 to 1966.

One of the most controversial provisions of the Dependents' Medical Care Act was that which allowed all military dependents "free choice" in the selection of either military or civilian hospitals for their inpatient care. This provision, inserted into the law on the recommendation of the American Medical Association, was the first to be attacked by members of Congress. In 1958 the House Appropriations Committee directed that a limitation be placed on this provision. They felt that military medical facilities "are not being used to their optimum economic capacity [Ref. 25]." To stress their concern they imposed a ceiling of $60 million on the Fiscal Year 1969 Dependent Medical Care expenditures. The Senate Appropriations Committee agreed with the House on the spending limit. The full Senate, however, did not agree. The appropriation act for that year for dependent medical care was $12 million over the ceiling desired by the House of Representatives. In the Joint Conference Committee, the Senate action prevailed, but, at the insistence of the House,

the bill contained a warning that military facilities must be more fully utilized [Ref. 26].

In response to the congressional criticism the Secretary of Defense issued a directive which ordered "rigid restrictions on the use of MediCare by dependents." The directive required dependents residing with their sponsors to "utilize uniformed services medical facilities if available and adequate [Ref. 27]." If such facilities were not available, the dependent had to receive a permit from the local commander in order to obtain "authorized care from civilian sources at government expense." The only exception allowed to this requirement was for bona fide emergency conditions. The directive further specified several types of medical care which would no longer be considered as authorized benefits of the Program. Those types of care which were eliminated were:

a. The treatment of fractures, dislocations, lacerations and other wounds which were normally treated on an outpatient basis.

b. Termination visits made to a physician's office prior to final discharge from his care.

c. Pre- and post-surgical tests and procedures which were normally accomplished as an outpatient.

d. Neonatal visits for "well baby" checkups.

e. The treatment of acute emotional disorders.

f. All elective surgery including non-acute tonsillectomies, hernias, and interval appendectomies.

Other congressional action in 1958 amended Title 10 of the United States Code. Chapter 55 was amended by the insertion of a statement of purpose into the law. After the amending action the statement read, in part, " . . . to create and maintain high morale in the uniformed services by providing an improved and uniform program of medical and dental care for members and certain former members of those services and for their dependents." Congress also added a sixth category of authorized care. This amendment allowed inpatient care for up to one year for "special cases" of nervous, mental, or chronic conditions. These "special cases" could not, however, include domiciliary care [Ref. 28].

In Fiscal Year 1960, the Dependent Medical Care budget requested by the Department of Defense and approved by Congress was $88.8 million [Ref. 29]. In addition, all of the services eliminated in October 1958 were fully restored as of 1 January 1960. The MediCare Permit was retained, but was given a new name. It was to be known as a Non-Availability Statement [Ref. 30]. By mid-1960 it was apparent that the costs of the Dependent MediCare would continue to rise. The size of families was growing rapidly and the costs of medical care in civilian facilities was rising at a rapid rate [Ref. 31]. During Fiscal Year 1961, the number of eligible family members would exceed 3.74 million, more than 200,000 above the level of eligible persons in 1959. Projected population figures for Fiscal Year 1962 would add another 80,000

persons to the list of those eligible for dependents medical care [Ref. 32].

An important area of contention between Congress and the Defense Department during this time period involved the question of programming of dependent care facilities in new military medical facility construction. The Secretary of Defense, in 1961, had ordered the elimination of such features from the plans of future medical facilities [Ref. 33]. By the middle of 1962 he had rescinded his order because of the impact that their elimination would have had on the overall cost of the Dependent Medical Care Program [Ref. 34]. Throughout the latter part of 1963 and the early months of 1964, both the Department of Defense and Congress completed several studies of the Dependent Medical Care System. The primary concern of these studies was the lack of medical care for retired personnel and their dependents. The 1956 law allowed retired persons to obtain medical care in military facilities on a "space available" basis. It did not permit them to use civilian medical facilities other than at their own expense. The rapidly growing number of retired persons and dependents had resulted in creating a heavy demand on the already crowded military medical facilities. In response to this demand, and as a result of numerous studies, the Defense Department sent a proposal for retirees medical care to Congress in June 1964. Congress, the proposal declared, had a "moral obligation" based on historical precedents and other considerations to

"endorse government sponsored medical plans for retired persons." The Defense proposal suggested four possible solutions to the problem.

a. Congress could extend the provisions of the Dependent Medical Care Act of 1956 to include the retired population. The retirees deductible payments would be $100 or even $150 versus the $25 that active duty persons paid.

b. Congress could direct that all retired care would be at military facilities only. Such care would be on the basis of a priority system; those retired with 30 or more years of service or for medical disability would receive the highest priority.

c. Congress could initiate a special type of Federal Employees Health Insurance Plan. This plan would offer several choices: a government-wide benefits-in-kind program, a government-wide indemnity plan, employees' organizations plans (group practice plans), or a combination of the best features of all of the plans.

d. The last proposal was a combination of the first two proposals and would permit the military to program 10 percent of all hospital beds in new construction for retired use. The remainder of the retirees and their dependents could use the Dependent Medical Care System [Ref. 35].

A special House Armed Services Subcommittee under the chairmanship of Congressman L. Mendel Rivers, in its report to the House of Representatives on the Utilization of

Military Medical Facilities stated that the government did indeed have an obligation to provide medical care to military personnel and to their dependents. The report, issued in the latter part of 1964, further declared that in the future, hospital beds should be "programmed on estimated workloads in all categories of personnel eligible for care [Ref. 36]." This last statement is a little ambiguous since another recommendation in the report required that no beds or inpatient facilities should be programmed for retired persons or their dependents. The committee's report also stated, "it is clear to the subcommittee that in future years a major portion of care must come from civilian facilities if it becomes governmental policy to provide such care."

As a result of the studies and special hearings on dependent medical care, three separate bills were introduced in Congress in the early months of 1966. One of the bills was for medical care for retirees and their dependents. It would require eligible persons to pay 25 percent of all medical care costs. It also contained a provision that made the wives and children of deceased military persons eligible for medical care. Another important provision of this bill specified that all retirees would lose their eligibility for such medical care at age 65 when they would become eligible for the Social Security MediCare System. If for some reason they did not qualify for Social Security benefits, they would be covered under the provisions of this particular bill [Ref. 37].

A second bill provided for care of handicapped children of active duty personnel. Types of care which would be authorized included residential care for training, rehabilitation, and special education for the moderately, severe, and profoundly retarded or seriously physically handicapped children. The serviceman would pay between $25 and $250 per month, depending on his rank, as his share of the total cost of such care.

The third bill introduced was to provide outpatient medical care for dependents of active duty personnel. If this care was obtained from civilian facilities, the serviceman would pay 20 percert of the total cost. Outpatient care would be free on a space available basis, as it had been for many years, in the military medical facilities. This particular type of benefit had been considered by Congress during the enactment of the 1956 law but was not included in the final version of that law because, as Secretary of Defense Cyrus Vance later explained:

> Inclusions of such benefits was not a common practice in group health plans then being offered by industry and labor.
>
> Many types of cases which ten years ago would have been treated on an inpatient basis are now treated on an outpatient basis. Another significant development during the interim was the establishment of the Federal Employees Health Benefits Program, under which the dependents of civilian employees of the Government receive civilian outpatient care.
>
> It is clear that while the practice of medicine has changed and the benefits, including outpatient coverage offered by most health plans have been

> expanding rapidly, the benefits provided under the Dependent Medical Care Program have remained frozen at the 1956 level [Ref. 39].

After several days of hearings, the House Armed Services Committee reported to the House of Representatives a single bill that encompassed the provisions of the three original bills and included several provisions that were entirely new. One of the new provisions authorized Title III retirees to receive care in the "retired medical care" category of benefits. Another provision required the Department of Defense to program five percent of all beds for the use of retirees in any future medical construction. Still another provision would require the government to pay the same amount for civilian care for dependents of retired personnel as for dependents of active duty personnel. Stated another way, this provision meant that the retirees would have the same deductible and co-payment requirements that active duty personnel enjoyed. There was also a formula under which dependent medical care would never be less than the high option of health benefits under the Social Security MediCare Plan as of the first of July of the year of enactment.

The bill also contained formulas for calculating the percentage of medical care costs which would be paid by the serviceman for treatment under the handicapped portion of the bill. These formulas assured the active duty man that payments he would be required to make for that type of care would not exceed one-fourth of the toal combined contribution

of the government and himself. Retirees, through a special saving clause, were assured that they would continue to receive whatever benefits they were entitled to prior to reaching age 65, even though they would also be covered by the Social Security benefits [Ref. 40].

In reporting the bill, Congressman F. Edward Hebert, chairman of the subcommittee that rewrote it, told the House that this bill would "give members of the uniformed services a singularly lifelong program of medical care for themselves and their families, and as such it is a foundation on which the military services can build an improved record of career retention." He also stated that the committee "believes that the program will make a great contribution to the morale of our military . . . who will have the assurance that their families, no matter where they reside, will receive first class medical care at the very minimum of cost [Ref. 41]."

The first witness to appear before the Senate Armed Services Subcommittee when it began its hearings in June 1966 was Senator Robert Kennedy. He offered an amendment that provided for broader coverage and benefits for handicapped dependents, for the inclusion of well-baby care, for psychiatric services for mentally ill persons, and authorized immunizations and physical examinations for dependents who were to accompany the serviceman overseas [Ref. 42].

Although many other witnesses spoke in favor of Senator Kennedy's amendment and in favor of the House bill,

the Senate Subcommittee severely cut the House version. The Senate version delayed the effective date by one full year, provided for a higher cost-sharing formula, and dropped the retired person's eligibility for Dependent Medical Care when he reached age 65. The cost-sharing formula desired by the subcommittee specified a $50 deductible per person, with a family maximum deductible of $100, plus 20 percent of all additional costs for outpatient care for dependents of active duty personnel. Retired persons and their dependents would have to pay the first 25 percent of all of the costs of civilian medical care that they received. The eligibility of Title III retirees and the requirement to program beds in military medical facilities for retired persons were also eliminated in the Senate's bill. Their version of the bill did, however, broaden the handicapped program passed by the House by adding mentally retarded or physically handicapped wives to the list of persons eligible to receive specialized care. Eligible persons could also receive eye examinations in military medical facilities under still another provision [Ref. 43].

The two versions of the bill went into Joint Conference Committee in mid-September 1966. By the end of the month, the final version of what would come to be known as the Military Medical Benefits Amendments of 1966 had been approved by both houses of Congress [Ref. 44]. These amendments and the Dependent Medical Care Act of 1956, as codified in Title

10, Section 1077 to 1085, United States Code, form the basis of all dependent care as it is known today.

DOD INTERPRETATION OF THE LAW

The first Defense regulations on the new dependent medical care program or, as it was now titled, the Civilian Health and Medical Benefits Program for the Uniformed Services (CHAMPUS) was a complex document. The regulations required the inclusion of certain specific data on all dependent and retired personnel's identification cards. It outlined the separate systems for claims submissions. Claims could be processed in one or more ways depending on the type of inpatient or outpatient care received. For inpatient care the dependent was required to complete certain parts of the claims forms at the hospital and the hospital would take care of completing the claim and submitting it to the designated fiscal agent.

For outpatient claims the process was not so simple. The dependent had to pay all of the charges up to the deductible limit. If, however, a payment to a health care provider exceeded the deductible, the dependent had to submit a claim to the proper fiscal agent (each state had a different one) with all receipted bills substantiating that the deductible limit had been paid attached to the claim form. The fiscal agent would then furnish the dependent with a certificate that stated that the deductible had been met. By presenting this certificate the next time they needed outpatient care, the

dependents would have to pay only 20 percent of the total cost of such care. The provider of the care would then submit a claim to the proper fiscal agent who would pay the government's share of the total cost [Ref. 45].

The expanded program had been in effect for less than a year when Congress and the Defense Department began considering changes to it. One of the important initial changes permitted the use of "private-profit" facilities for treating mental and physically handicapped dependents [Ref. 46]. A Department of Defense policy ruling stated that facilities that discriminated in admissions or treatment of patients "on the basis of race, color, or national origin" were no longer considered as eligible providers of care [Ref. 47]. Another policy statement included therapeutic abortions and sterilization procedures as a CHAMPUS benefit [Ref. 48]. One of the more liberal policy rulings pertained to the billing procedures to be used by providers of orthodontic care for physically handicapped dependents. Other policy statements and regulation changes which benefited dependents were the inclusion of payments for the cost of specialized equipment prescribed by a physician as being necessary to properly treat a dependent, for the services of assistant surgeons, anesthesiologists, private duty nurses in special instances, podiatrists, and psychologists, for routine dental care for expectant mothers when so ordered by a physician, and for the cost of treating alcoholism, obesity, and drug addiction if

such care was received while in an inpatient status [Refs. 49, 50, 51, 52, and 53].

A recent change was made to allow the handicapped dependents of Vietnam war dead to continue their care until age 21 or until they otherwise cease to be eligible for such care. The change applied to those dependents who were involved in a program of special care at the time of the serviceman's death [Ref. 54].

More recently, there have been several policy changes which have not benefited the dependent. One of these stated that non-availability statements would not be issued to expectant mothers who wanted to use natural childbirth procedures unless the military medical facility did not use that procedure [Ref. 55]. Another policy change required that orthodontists return to monthly billing procedures from the quarterly procedures that had been instituted a year before [Ref. 56]. One of the latest policy changes reduced the allowable benefits that a handicapped child could receive in the area of treatment termed psychotherapy [Ref. 57].

CONCLUSION

If anything, the foregoing history of the evolution of the present day dependent medical care program illustrates the scope of the considerations which impinge upon the decision process related to its changes. We hope that providing in one place this collection of factual data will make those interested in CHAMPUS and other related dependent care costs more aware of the implicit intent of many sections of the present program, as well as the range of potential ramifications of proposal changes. It is much easier to say that military salaries have reached parity with the private sector and to, therefore, urge repeal of all or part of the enabling legislation described above than to attempt to reinstitute such a program if this view leads to, say, a drastic shortfall in required military manpower.

APPENDIX A

SUMMARY OF DEPENDENT MEDICAL CARE LEGISLATION

1799 - "An Act in addition to "An Act for the Relief of Sick and Disabled Seamen" (a)", 2 March 1799.
Established that active duty and retired personnel of the Navy and Marine Corps would have deducted from their pay a sum of twenty cents per month to provide for their care if they became sick or disabled.

1811 - "An Act Establishing Naval Hospitals," 26 February 1811.
Provided that funds from above law were to be used to form a "fund for Navy Hospitals." Further provided that active duty and retired Navy and Marine Corps personnel could be admitted to these hospitals.

1884 - "Appropriations Act for the Army," 5 July 1884.
Contained a proviso in Medical Department Appropriations to allow Army Medical Officers to treat families of officers and enlisted men without charge.

1899 - "An Act to reorganize and increase the efficiency of the personnel fo the Navy and Marine Corps of the United States," 3 March 1899.
This act, in Section 13, stated that commissioned officers were to receive the same pay and allowances as Army officers of equal rank. This was interpreted by the Navy as allowing Navy Medical Officers to treat active duty dependents in Navy medical facilities.

1943 - "An Act to provide for the expansion of Navy medical facilities," Public Law 51, 10 May 1943.
This act defined the word "dependent" and spelled out that care was to be provided for "only acute medical and surgical conditions."

1956 - "Dependent Medical Care Act," Public Law 84-569, 7 June 1956.
This was the basic program for dependent medical care. Major points were (a) patient payment of $25 for inpatient care from civilian sources, (b) inclusion of maternity care from civilian sources as a benefit, and (c) retired and their dependents could use military facilities.

1956 - "Amendment to Title 10, USC," 10 August 1956.
This amendment, in essence, codified the above law as part of Title 10, United States Code.

1958 - "Amendment to Title 10, USC," 2 September 1958.
This amendment changed the purpose statement and added a special case consideration for inpatient care for nervous and mental and chronic conditions.

1965 - "Amendment to Title 10, USC," 16 September 1965.
This amendment provided that future military hospital construction should include facilities for obstetrical care.

1966 - "Military Medical Benefits Amendments of 1966," Public Law 89-614, 30 September 1966.
These amendments to the basic law provided for outpatient care for active duty dependents, made provisions for care (inpatient and outpatient) for mental and physically handicapped dependents of active duty and provided for civilian inpatient and outpatient care for retired military personnel and their dependents.

LIST OF REFERENCES

1. An Act in addition to "An Act for the Relief of Sick and Disabled Seamen" (a), Statutes at Large, I-II, Chap. XXXVI, (1799).

2. An Act Establishing Naval Hospitals, Statutes at Large, I-II, Chap. XXVI, (1811).

3. Act of 5 July 1884, Army Appropriations, Statutes at Large, XXIII, Chap. 217, (1884).

4. An Act to Reorganize and Increase the Efficiency of the Personnel of the Navy and Marine Crops of the United States, Statutes at Large, XXX, Chap. 423, (1899).

5. Act of 10 May 1943, Public Law 51, Statutes at Large, LXII, Chap. 95, (1943).

6. Nelson, Rita, "Bill Gets AMA Blast," Navy Times, 1:22, 15 March 1952, 1.

7. "Officer-Family Medicare Thru O-3 Defense Goa," Navy Times, 1:23, 22 March 1952, 3.

8. "Pentagon to Ask Equitable Family Medical Care Bill," Army-Navy Journal, 91:1045, 21 November 1953, 337, 343.

9. "New Medical Care Plan Introduced; Government Will Help Defray Costs," Armed Forces Journal, 91:1045, 1 May 1954, 1.

10. "Defense Dept. Readies Medical Care Bill, Will Reflect Moulton Report Proposal," Army-Navy Journal, 91, 20 February 1954, 730.

11. "Congress Goes to Work on Dependent Medical Care, Will Cost $157 Million," Army-Navy Journal, 92, 22 January 1955, 601.

12. "Hoover Report Asks Free Med Care Ban," Army-Navy Journal, 92, 5 March 1955, 781.

13. "AMA Battle Jams Plan for Medicare," Navy Times, 4:32, 21 May 1955, 1.

14. Bourjailey, Monte, Jr., "Medicare Bill Back in Congress," Navy Times, 4:43, 6 August, 1, 12.

15. "Chairman Vincent Introduces New Medical Plan; Option Would Cost $3 Per Family," Army-Navy Journal, 93, 7 January 1956, 1.

16. "Ford, John J., "Dependent Medicare Bill May Give Free Hospital Insurance," Navy Times, 5:15, 28 January 1956, 1.

17. Ford, John J., "Medicare Gains; Bill Improves," Navy Times, 5:17, 11 February 1956, 1.

18. "Fast House Action Seen on Kin Care," Navy Times, 5:19, 25 February 1956, 12.

19. Ford, John J., "Dependent Care Cost Rise Voted," Navy Times, 5:29, 5 May 1956, 1, 12.

20. "Senate Group Approves MediCare; Maximum Cost of Civilian Hosp.," Army-Navy Journal, 93, 5 May 1956, p. 3.

21. "Senate OKs Family MediCare; Conference Slated; Final Approval Seen This Month," Army-Navy Journal, 93, 19 May 1956, 3.

22. "MediCare Bill Compromise Reached, Quick Passage," Navy Times, 5:32, 25 May 1956, 6.

23. "Family Medical Care Program Permits 'Free Choice'; Wins President's Approval," Army-Navy Journal, 94, 20 October 1956, 1.

24. "President Says Plan Will East Worries," Army-Navy Journal, 94, 20 October 1956, 11.

25. "Cut in Funds Perils Medicare Program; DOD Study Report Due Next Week," Army-Navy Journal, 95, 2 August 1958, 28.

26. "Budget Action Protects Medicare," Army-Navy Journal, 95, 9 August 1958, 1+.

27. "DOD Orders 'Rigid' Medicare Restrictions; Cutback Becomes Effective on 1 October," Army-Navy Journal, 96, 6 September 1958, 1+.

28. An Act to Amend Title 10, United States Code, Statutes At Large, LXXII, (1959).

29. "$88.8 Million Medicare Program Wins Committee Approval," Army-Navy Journal, 96, 6 June 1959, 4.

30. "Medicare, Moving, Policy Changes," Army-Navy-Air Force Journal, 97, 12 December 1959, 1.

31. "Medicare Costs will Rise $15 Million Because Families Are Growing," Army-Navy-Air Force Journal, 97, 19 December 1959, 16.

32. "Service Families Will Add 80,000 Next Year, Medicare Cost Will Rise," Army-Navy-Air Force Journal, 98, 6 May 1961, 24.

33. "SecDef Orders Service Families to Pay $1 for Each Sick Call," Army-Navy-Air Force Journal, 99, 16 December 1961, 16.

34. "Family Medical Care Reaffirmed," Army-Navy-Air Force Journal, 99, 17 February 1962, 1.

35. "Multi-Million Dollar Plan Stress Medicare 'Moral Obligation,'" Army-Navy-Air Force Journal and Register, 101, 20 June 1964, 1, 18.

36. U. S. Congress, House, Committee on Armed Services, Military Hospital Construction and Utilization Policies Report of Hearings, before a special subcommittee on Construction of Military Hospital Facilities, of the Committee on Armed Services, 21 September 1964.

37. "Medicare Plan for Retirees and Dep.," Journal of the Armed Forces, 103, 14 March 1966, 6, 14.

38. "Care for Handicapped Children," Journal of the Armed Forces, 103, 14 March 1966, 14.

39. "DOD Seeks Outpatient Medicare for Dependents," Journal of the Armed Forces, 103, 14 March 1966, 15.

40. U. S. Congress, House, Committee on Armed Services, Military Medical Benefits as Proposed in H.R. 9271, H.R. 13582, and H.R. 13583. Hearings before a subcommittee of the Committee on Armed Services, 89 Congress, 2nd Session, 1966.

41. "Committee Rewrites Medicare Proposals," Journal of the Armed Forces, 103, 2 April 1966, 1, 27.

42. U. S. Congress, Senate, Committee on Armed Services, Military Medical Benefits. Hearings before a subcomittee of the Committee on Armed Services, 89th Congress, 2nd Session, 1966.

43. U. S. Congress, Senate, Committee on Armed Services. Military Medical Benefits Amendments of 1966. S. Report 1434, 89 Congress, 2nd Session, 1966, Senate Miscellaneous Reports on Public Bills, Vol. III.

44. U. S. Congress, House, Committee on Armed Services. Military Medical Benefits Amendments of 1966. Conference Report. House Report 2064, 89th Congress, 2nd Session, 1966 (to accompany H.R. 14088). House Miscellaneous Reports on Public Bills, V VI.

45. "Defense Dept. Sets Medicare Claim Rules," Journal of the Armed Forces, 21 January 1967, 19, 31.

46. "DOD Urges Revision of Medicare Rules," Journal of the Armed Forces, 29 July 1967, 8.

47. "DOD Bans Medicare Payments to Hospitals That Discriminate," Armed Forces Journal, 7 September 1968, 28.

48. "CHAMPUS OK's Some Abortions for Dependents," Navy Times, 20:14, 13 January 1971, 3.

49. "Defense, CHAMPUS Argue Teeth Straightening Fees," Navy Times, 20:18, 10 February 1971, 50.

50. "CHAMPUS Allays Cost of Equipment, "Navy Times, 20:24, 24 March 1971, 1.

51. "CHAMPUS Shares Subsidiary Costs," Navy Times, 20:26, 7 April 1971, 7.

52. "Expectant Mothers to Get Dental Care," Navy Times, 20:32, 19 May 1971, 40.

53. "CHAMPUS Benefits Extended to Addicts," Navy Times, 20:35, 9 June 1971, 25.

54. "Handicapped Aid Reg. Changed by CHAMPUS," Navy Times, 20:45, 18 August 1971, 38.

55. "CHAMPUS Curbs Birth Services," Navy Times, 22:17, 7 February 1973, 1.

56. "CHAMPUS To Cut Dental Payments," Navy Times, 22:25, 4 April 1973, 22.

57. "Psychotherapy Controls Tightened," Navy Times, 23:44, 14 August 1974, 8.